(43) (41)

Nos. 95-1858 and 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, et al.,

Petitioner,

vs.

TIMOTHY E. QUILL, M.D., et al.,

Respondent.

and

STATE OF WASHINGTON, et al.,

Petitioner,

vs.

HAROLD GLUCKSBERG, M.D., et al.,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Second Circuit And To The United States Court Of Appeals For The Ninth Circuit

BRIEF AMICUS CURIAE OF THE EVANGELICAL LUTHERAN CHURCH IN AMERICA IN SUPPORT OF PETITIONERS

EDWARD MCGLYNN GAFFNEY, JR.
Valparaiso University
School of Law
Wesemann Hall
Valparaiso, IN 46383
219-465-7834
FAX: 219-465-7872
* *Counsel of Record*

PHILLIP H. HARRIS
General Counsel
Evangelical Lutheran
Church in America
8765 West Higgins Road
Chicago, IL 60631
773-380-2805
FAX: 773-380-2977

SUSAN D. REECE MARTYN
HENRY J. BOURGUIGNON
University of Toledo
College of Law
Toledo, OH 43606
419-530-4212
FAX: 419-530-2821

Attorneys for Amicus Curiae

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

47pp

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

STATEMENT OF INTEREST

The Evangelical Lutheran Church in America [ELCA] is the largest Lutheran denomination in North America and the fifth largest Protestant body in the United States. It has approximately 11,000 member congregations which in turn have approximately 5.2 million members. As part of its mission, the ELCA supports twenty-eight colleges, eight theological seminaries, 400 missionaries in 50 countries, 450 chaplains in the armed forces, and 260 social service institutions, including hospitals, hospices, long-term care and residential facilities for older persons, and facilities for adults, youth and children with special needs.

The ELCA began its official existence January 1, 1988, as a merger of three predecessor bodies: The Lutheran Church in America [LCA], the American Lutheran Church [ALC] and the Association of Evangelical Lutheran Churches [AELC]. These groups trace their history in this country to the seventeenth century and in Europe to the Reformation in Germany. For deeply religious reasons, Lutherans view the human condition as flawed and broken, sustained only by the grace of God. In a century marked with wars, racism, genocide and other massive evil, secular decision-makers have ample evidence to distrust the rosy picture of inherent human goodness and generous human compassion offered as the predicates for the decisions below.

The guiding principles for specific positions of the ELCA on issues of social ethics are contained in its own social statements and in those of its predecessor church bodies. Task force reports support these statements and messages draw out their implications. Three such documents are directly relevant to the issues discussed in this brief: the 1992 Message of the ELCA on End-of-Life Decisions, a 1982 Social Statement on Death and Dying adopted by the Eleventh Biennial Convention of the LCA, and a paper issued in 1977 by the ALC's Task Force on Ethical Issues in Human Medicine.

The 1992 ELCA Message, appended to the brief as Appendix A, states: "The integrity of the physician-patient

relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death. However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. . . . We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased." App. 5-6.

The 1982 LCA Social Statement states: "Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter [from refusing treatment]. This is frequently called 'active euthanasia' or 'mercy killing' (as contrasted with . . . withholding or withdrawing medical treatment, thereby allowing death to occur from a disease or injury). Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience. Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which elicit a renewed commitment to living."

The 1977 ALC paper states: "We affirm that direct intervention to aid the irremediably deteriorating and hopelessly

ill person to a swifter death is wrong. While direct intervention in many cases may appear 'humane,' deliberate injection of drugs or other means of terminating life are acts of intentional homicide. This deliberate act is far removed from decisions which allow people to die – like shutting off a life-support machine or even withholding medication. Permission for the normal process of death is an act of omission in the spirit of kindness and love within the limits of Christian charity and legal concerns. Direct intervention to cause death, known as active euthanasia, can not be permitted. We affirm there is a distinct moral difference between killing and allowing to die."

Letters from the parties consenting to the filing of this brief have been filed with the Clerk of this Court pursuant to Rule 37.3.

SUMMARY OF ARGUMENT

The homicide laws in all of the states prohibit the purposeful, knowing, reckless or negligent killing of another human being. About two-thirds of the states also expressly prohibit assisting or aiding suicide. All of these criminal bans refuse to recognize the consent of the victim as a defense. The two lower courts reviewed in these cases have ruled that the federal constitution *requires* the States to abandon this effort to surround human life at a most vulnerable point with that protection.

The lower courts offer a naively optimistic promise that a regime of physician-assisted suicide would protect the values of liberty and equality. The Ninth Circuit found a liberty interest in the Due Process Clause of the Fourteenth Amendment that would nullify a Washington statute prohibiting physician-assisted suicide. The methodology of substantive due process is ill-suited for grounding a constitutional right to suicide, let alone a right to involve the medical profession in administering lethal poison to kill another person. The Due Process Clause has been used to require that all states protect substantive liberties such as free exercise of religion, freedom

of speech, and freedom of the press. It has never been used to allow the direct intentional killing of another or providing the means of ending life to another person. The Court should not invoke substantive due process to repudiate the constant teaching of the common law that the human person is free to refuse medical treatment, but that a State may reasonably prohibit all persons, including physicians, from acting affirmatively to end human life. The line we insist should be maintained between killing a person and allowing a person to die might not always be perfectly clear, but over a long period of time it has been vastly more effective at preventing abuse than the slippery standards offered by the Ninth Circuit. A regime of physician-assisted suicide would actually exalt physician control over patients and would thus radically undermine personal freedom.

The Second Circuit nullified a similar New York statute as a violation of the Equal Protection Clause. There is no fundamental right to take one's own life, let alone a right to assistance by a physician in ending one's life. Hence New York has a rational basis for maintaining its prohibition of physician-assisted suicide. New York recently completed a lengthy and exhaustive study culminating in a comprehensive report unanimously rejecting the adoption of physician-assisted suicide. The New York report concluded that the regime of physician-assisted suicide in the Netherlands had resulted in massive involuntary euthanasia, and it unanimously repudiated a practice that it legitimately equated with radical undermining of its commitment to equality of all persons, especially older persons, the poor, and those with disabilities. A state is entitled to considerable deference in choosing among policy alternatives. That traditional deference is heightened where the state is acting to fulfill its solemn duty to protect life and to express special concern for the most vulnerable among us.

Both lower courts trivialize the enormous complexity of the issues underlying the social experiment they find imbedded in the Fourteenth Amendment. They make unfulfillable

promises, and they grossly underestimate the peril to liberty and equality inherent in a scheme of physician-assisted suicide.

ARGUMENT

I. Preserving the distinction between killing a person and allowing a person to die protects personal liberty; a regime of physician-assisted suicide does not.

A. The distinction between killing a person and allowing a person to die is well grounded in the common law.

These cases implicate the deepest philosophical concerns about the nature and destiny of the human person. The traditions of this nation have for centuries preserved a delicate balance between individual responsibility and the communal dimension of human life. Each of us is precious and unique, born into communities that support us and shape our very existence: families, religious communities, neighborhoods, cities, states, and the nation itself. By radically transforming the meaning of the fundamental values of liberty (Part I) and equality (Part II), these cases threaten to do irreversible damage to that balance between the individual and the community.

For over two millennia physicians have served their patients with an understanding that their duty was to heal and to support human life in all circumstances. *See* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 330 (4th ed. 1994) (citing the Hippocratic Oath, with its promise "to do no harm"). This duty corresponds to a communal concern to protect the health and well-being of the human person.

The common law also preserved a delicate balance between the individual and the community by acknowledging that a competent person can decline medical treatment. See *Mills v. Rogers*, 457 U.S. 291, 294 note 4 (1982); W. Keeton, *Prosser and Keeton on the Law of Torts* § 18, at 116-19 (5th

ed. Supp. 1984). Indeed, physicians committed common-law torts if they did not first obtain their patients' informed consent. While Justice Cardozo was a judge on the New York Court of Appeals, he wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). *See also Natansen v. Kline*, 186 Kan. 393, 350 P. 2d 1093, 1104 (1960); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905). These cases refer to the right to protect the integrity of one's body from intrusion, and not to any purported right to consent to be killed. Under the common law of battery, then, physicians may allow a patient to die by respecting that person's lack of consent to continuing medical treatment. Aiding such a person's death by causing a bodily intrusion, on the other hand, is clearly a tortious battery whether or not the person consents. *Id.*

Similarly, the criminal law of all the states prohibits the killing of another, even where the victim consents. Withdrawing medical treatment, on the other hand, is not killing and therefore not criminal because it is viewed as an omission by the physician where the patient or appropriate surrogate has elected to decline further medical treatment. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). This distinction is the legal analogue to the ethical teaching of the ELCA referred to above in the statement of interest, concerning the distinction between killing a person, which we view as highly immoral, and letting a person die, which we acknowledge can be ethically permissible, at least under some circumstances.

B. There is no substantive liberty interest in taking one's life, much less in having a physician "assist" in this process.

Against this clear teaching of the common law of torts and crimes, we assess the constitutional provision relied upon by the Ninth Circuit for its conclusion: "No State shall deprive any person of . . . liberty without due process of law. . . . " U.S. Const. Amend. XIV. This clause obviously cannot mean that no state may ever restrict the liberty of any of its citizens. All of the states do that all the time by a variety of regulatory schemes that frequently entail fines or other penalties that amount to deprivations of liberty. The primary safeguard referred to by the Due Process Clause is obviously procedural. But this Court has also relied upon this clause to ensure that all of the states would protect fundamental liberties with at least as much care as is required of the national government.[1]

The extent to which a right might be regarded as immune from state regulation or prescription is not absolute, but may vary according to the nature of the right and the context within which it is asserted. Examples of liberty interests that this Court has protected under the Due Process Clause against state regulation include freedom of speech, *Gitlow v. New York*, 268 U.S. 652 (1925); freedom of the press, *Near v. Minnesota*, 283 U.S. 697 (1931); and freedom of religion, *Cantwell v. Connecticut*, 310 U.S. 696 (1940). As high as these fundamental liberties rank in our constitutional order, *Thomas v. Collins*, 323 U.S. 516, 530 (1945), *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 303 (1943), they do not mean that everyone invoking them is automatically guaranteed that he or she is free from the burden of reasonable governmental regulation. This outcome is determined by

---

[1] The states are clearly free to surround human liberty with greater protection or more specific safeguards than is required by the federal Bill of Rights. *See, e.g., PruneYard Shopping Center v. Robins*, 447 U.S. 74 (1980).

a careful examination of the factual context within which a right is asserted, and by the adherence of the government to standards governing its own conduct. Despite Justice Black's persistent view in the absolute character of free speech, *The Bill of Rights*, 35 N.Y.U.L.Rev. 865 (1960), this Court has never thought to invalidate the libel laws of all fifty states. Despite the vital significance of a free press in a free and open society, *New York Times v. United States*, 403 U.S. 713 (1971), this Court has never held that this freedom gives the press greater access to governmentally held information than that enjoyed by the general public. *See, e.g., Saxbe v. Washington Post*, 417 U.S. 843 (1974); Stewart, *Or of the Press*, 26 Hastings L. J. 631 (1975). Or, to illustrate the varying content of parental liberty secured under substantive due process, *Pierce v. Society of Sisters*, 268 U.S. 510 (1926), invalidated a provision of the Oregon constitution that required all children to attend schools operated by the government, but *Pierce* emphatically does not mean that the states must abandon their truancy laws. *Meyer v. Nebraska*, 262 U.S. 390 (1923) invalidated a statute prohibiting the teaching of the German language, but *Meyer* does not mean that the states or the thousands of local school districts are required to teach German or otherwise lack broad discretion to regulate the content of the educational curriculum, at least in the schools they operate.

The relative character of rights subsumed under the Due Process Clause is directly relevant, even critical, to the analysis of these cases. The Ninth Circuit explicitly recognized this approach, yet its opinion is a classic example of careless expansion of this Court's treatment of substantive due process. Taken along the natural trajectory of its logic, the approach of the Ninth Circuit would for all practical purposes mean that no State may restrict the liberty of any of its citizens on this matter, including those who are depressed or simply tired of living. This conclusion is clearly at odds with the text of the Due Process Clause and with the history of its interpretation by this Court. Worse yet, this approach would

nullify the sovereign obligation of the several states to protect life, a duty that is demonstrably clear in the text of the same provision: "No state shall deprive any person of *life* . . . without due process of law."[2]

Reflecting considerable restraint, this Court's general standard for reviewing substantive due process claims is deferential to legislative judgments, unless they impinge upon fundamental rights. The Ninth Circuit explicitly acknowledged that the right it sought to protect is not "fundamental" in the sense that it is so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Curiously, however, the Ninth Circuit concluded that Washington has no legitimate interest in prohibiting physician-assisted suicide.[3]

The Second Circuit expressly rejected the substantive due process claims pressed in these cases, No. 95-1858, Pet.

---

[2] This issue is now before the Ninth Circuit in an appeal from the decision of a district court enjoining a provision in the Oregon constitution recently enacted by initiative. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), on appeal sub nom. *Lee v. Harcleroad* (9th Cir. Nos. 95-35804, 95-35805, 95-35854, 95-35948, and 95-35949). The ELCA joined an amicus brief in *Lee* urging that life is an inalienable fundamental right that may not be "waived" by any class of citizens.

[3] The Ninth Circuit formally recognized that "State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests." No. 96-110, Pet. App. A-102. But this language is not reliable as a guide to the lower court's own decision, for the court went to great lengths to dismiss every state interest that might justify judicial restraint as illegitimate or irrelevant. *Id.*, A-65 to A-101. Still less is the Ninth Circuit's opinion reliable as a prediction of the likely outcome in a regime of physician-assisted suicide. In the Netherlands the very categories relied upon by the Ninth Circuit as safeguards against abuse – limiting assisted suicide to cases where the patient is competent, voluntarily opts for death, is terminally ill, and is suffering, and limiting the persons who may offer such assistance to doctors – all broke down within years of the relaxation of the legal standards governing the ending of human life. See 22-23 below.

App. 16a-20a, noting that this Court stated in *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986), that it is not "inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause." According to the Second Circuit, "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those who, in the final stages of terminal illness, seek the right to hasten death." No. 95-1858, Pet. App. 19a. The Second Circuit further noted the Court's reluctance "to expand the concept of substantive due process because guideposts for responsible decisionmaking in this uncharted area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). And the Second Circuit concluded: "Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area." No. 95-1858, Pet. App. 20a. For the reasons set forth above, we urge the Court not to find a new right to physician-assisted suicide in the Due Process Clause, but to allow the States to maintain a prohibition of physician-assisted suicide and to sustain a distinction – well grounded in the common law of torts and crimes – between killing a person and allowing a person to die.

C. Misguided reliance upon *Cruzan*

The Ninth Circuit relied on *Cruzan v. Director of Missouri Department of Health*, 497 U.S. 261 (1990). No. 96-110, Pet. App. A-58 to A-62. In *Cruzan* this Court considered whether the Fourteenth Amendment protected a liberty interest of a patient to refuse or to terminate medical treatment, even if it meant the patient would die. The Court held that the State could impose a stringent evidentiary standard to prove that an incompetent patient, while competent, had expressed a desire to have life-saving medical treatment terminated. In the process of the decision, a majority of the justices seemed to accept a right of a competent patient to

terminate medical treatment, even though it would clearly hasten death.

The extreme conclusion reached by the Ninth Circuit is not required by the majority opinion in *Cruzan*. Indeed, nowhere in all of the opinions in *Cruzan* did any member of this Court ever intimate the view ascribed to the Court by the Ninth Circuit in this case. *Cruzan* can be read as protecting a right to refuse medical treatment, *see Cruzan*, 497 U.S. at 269-80, or more narrowly as an evidentiary ruling sustaining a state's imposition of the clear and convincing evidence standard when this right is invoked as life nears its end, *id.* at 280-85, and at 292 (O'Connor, J., concurring). But *Cruzan* cannot be read as holding that the Due Process Clause protects an unqualified liberty interest of a person to suicide, much less that a dying patient has a right to involve physicians in acting against the centuries-old tradition reflected in the Hippocratic oath. To argue that the right to be free from medical intervention includes an affirmative right to assistance in dying flies in the face of the very limited language in *Cruzan*. The Ninth Circuit's view is also contrary to cases in which this Court has held that there is no right to state provision of assistance, even as to conduct the Court has found constitutionally protected. *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); *Beal v. Doe*, 432 U.S. 438 (1977).

Both before and after *Cruzan*, several commentators have recognized the importance of drawing a clear line between killing and letting die, because this distinction offered courts an objective standard that would enable them to recognize the right to refuse certain medical treatment without also recognizing a right to suicide or euthanasia. *See, e.g.*, Lawrence H. Tribe, Governmental Control Over the Body: Decisions About Death and Dying, *American Constitutional Law* § 15-11, p. 1365 (2d ed. 1988); Mark Chopko and Michael Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 520, 564-67 (1995).

D. Misguided reliance upon *Casey*

The Ninth Circuit also relied on language in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992). No. 96-110, Pet. App. A-56 to A-58. In reaffirming a person's liberty interest in controlling intimate and personal decisions about abortion, Justices O'Connor, Souter, and Kennedy wrote in *Casey*: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 112 S. Ct. at 2807. The Ninth Circuit cited this statement in *Casey*, Pet. App. A-56, and drew from it the conclusion that when patients are in great pain, they have a similar liberty interest not only to hasten their death rather than continue to live in pain, but also to implicate the medical profession in this choice. Pet. App. A-57 to A-58.

This analysis is seriously flawed. This court in *Casey* spoke only about a constitutionally grounded right to liberty in the context of defining the future and ongoing living of a life. This language should not be removed from the context of living to the context of death, where its meaning lies beyond all of us. The Court intimated no views whatever about a constitutionally grounded right to die. *See* Chopko and Moses, *Assisted Suicide, supra*, 70 Notre Dame L. Rev. 520, 558-64. The language from *Casey* cited above should not be removed from the context in which it was uttered. As Judge Noonan noted in the original panel decision in the Ninth Circuit, "It is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context. To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to

find these sentences 'almost prescriptive' in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request." No. 96-110. Pet. App. D-11.

E. The Impossibility of Establishing Reliable Criteria for Limiting Physician-Assisted Suicide

The inappropriateness of expanding the language in *Casey* cited above to the question presented in these cases is confirmed by focusing on the illusory nature of the lower court's attempt to confine the new right to physician-assisted suicide that they have discovered in the Fourteenth Amendment.[4] The lower courts defend the creation of a constitutional right to physician-assisted suicide because they are confident that this right would operate under five carefully confined conditions. They believe that the right will be exercised only by (1) *competent patients*, (2) who *voluntarily decide to hasten death*, (3) who are *terminally ill*, (4) who *are suffering acute pain*, and (5) to whom *a physician would prescribe or provide a lethal dose of medication for the patients to take, or would actually administer a lethal dose to the patients in some circumstances*. We comment briefly on each of these categories to illustrate how unstable and unreliable they are, and to call into question the claim that a regime of physician-assisted suicide would in fact promote personal liberty.

First, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *competent* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 11a, 12a, 19a, 24a, 31a, 33a; and No. 96-110, Pet.

---

[4] This section of the brief relies heavily on an article by Susan R. Martyn and Henry J. Bourguignon, *Physician Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, which will appear in 85 Cal. L. Rev. ___ (Mar. 1997). A copy of the manuscript has been served on the parties and placed in the Library of the Court.

App. A-10, A-11, A-12, A-14, A-17, A-20, A-21, A-29, A-59, A-60, A-62. This standard, however, is by no means a bright line test. Neither law nor medicine provides a simple, clear litmus test to determine patient competence. For a discussion of the complexity of the legal tests for competence, *see* John Perry, *Incompetency, Guardianship, and Restoration*, and *Decision-Making Rights over Persons and Property*, in Samuel Brakel et al, eds., *The Mentally Disabled and the Law* (1985); Thomas Gutheil and Harold Burstztjn, *Clinicians' Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings*, 143 Am. J. Psychiatry 1020 (1986); S. McCrary and A. Walman, *Procedural Paternalism in Competency Determination*, 18 Law, Med. and Health Care 108, 112 (1990). Serious illness, moreover, often requires powerful medications that can alter the patient's level of competence. So can pain and suffering, fear of an unknown future, and dependence on health-care providers. In the context of physician-assisted suicide, a patient should not be deemed competent unless he truly understands not only his medical condition, but also the health care options available to treat it, including care in alternative facilities or at home. And it would mean that alternatives to suicide be genuinely accessible to the patient. Competence in this setting is thus not easy or inexpensive to assure. Unlike other mistakes that occur around the issue of patient competence, a mistake in construing a patient's desires as a request for physician-assisted suicide is, of course, irreversibly fatal.

Second, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who *voluntarily* want to end their lives. *See, e.g.*, No. 95-1858, Pet. App. 5a, 34a; No. 96-110, Pet. App. A-9, A-10, A-11, A-12, A-14, A-17, A-18, A-20, A-21, A-49, A-65, A-75. At best, this line is elusive and treacherous.[5] If it is difficult to

[5] For example, the Ninth Circuit expressly approved nonvoluntary termination of life in the cases of incompetent patients. Pet. App. A-101, note 120.

determine whether a request for physician-assisted suicide is made by a competent patient, it is far more difficult to assure that such a choice is truly voluntary, for choice is often clouded. Many persons who request suicide are "beset with ambivalence, simply wish to reduce or interrupt anxiety or are under the influence of drugs, alcohol or intense pressure." Tom L. Beauchamp and James F. Childress, *Moral Problems of Suicide Intervention* in Tom L. Beauchamp and Robert M. Veatch, *Ethical Issues in Death and Dying* 127, 128 (1996). Further, such a person may entertain rescue fantasies. A "competent" request for suicide actually may convey a deep desire for relief from the distressing realities currently confronting the person. When this occurs, granting assistance in suicide actually disregards the patient's true intent. Edwin Ringel, *Suicide Prevention and the Value of Human Life*, in Beauchamp and Veatch, *supra*, at 144. Even if one assumes, as the Ninth and Second Circuits did, that a patient's suicide request can be truly voluntary, assessing what such a request means will often be impossible without a psychiatric evaluation. Depression, the major precursor of suicidal intent, worms its way into many serious illnesses and disabilities. And depression, especially among the elderly, often remains underdiagnosed and untreated. Given the dependence of ill persons on insurance companies and other health care providers whose motive is to maximize profits, moreover, a "right" to die could well be transformed into a duty to die imposed upon a helpless person to alleviate the burdens of rising medical costs. In this all too plausible scenario, true personal autonomy is lost when the quick way out is urged upon the patient by his doctor. It is bizarre to defend physician-assisted suicide as an exaltation of personal freedom. We call it a program of advancing the economic self-interest of large health corporations; we call it professional control over death and its discussion.

Third, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *terminally ill* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 15a, 25a; No. 96-110, Pet. App. A-9, A-10, A-13, A-14,

A-15, A-16, A-17, A-18, A-20, A-21, A-48, A-49, A-51. The timing of death, however, with its silent footsteps, often lies beyond the scientific prognostication of modern medicine. Thus state courts have noted the difficulty of defining the category, "terminally ill," with precision. "Predicting that a condition is 'terminal' within any specific time period or opining on the 'imminence' of death has been very difficult for the medical profession. . . . Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community." *Browning v. Herbert*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990). *See also* Joanne Lynn, *Caring at the End of Our Lives*, 335 New Eng. J. Med. 201 (1996) (noting that if the definition of "terminally ill" referred to persons with a 50 percent chance of living six months, most of the frail elderly in nursing homes would be considered terminally ill). Thus Judge Noonan noted accurately in No. 96-110, "The category created ["terminally ill"] is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. . . . If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it." No. 96-110, Pet. App. D-12. For a graphic example of a physician-assisted suicide involving a person who was by no means "terminally ill," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).[6] *See also* Yale

[6] According to one commentator, Kevorkian's primary goal as a pathologist has always been the use of tissue from newly dead bodies for medical experimentation. Robert A. Burt, *Choosing Death for Oneself/for Others* in Lotta Westerhill and Charles Phillips, eds., *Patient's Rights: Informed Consent, Access and Equality* 63, 80-82 (1994). Another commentator notes that medical advocates for assisted suicide like Kevorkian will be most successful with vulnerable women. Stephanie Gutmann, *Death and the Maiden*, 214 New Republic (June 24, 1996) 20-28. For example, in the case cited above, when Kevorkian assisted Janet Adkins to commit suicide, she had been diagnosed with Alzheimer's disease and feared what the disease would do to her in the future. She was 54 years old, was not in imminent danger of death, and was not suffering pain. Kevorkian did not independently confirm her diagnosis or attempt to discover whether she was depressed.

Kamisar, *"Are Laws Against Assisted Suicide Unconstitutional?"* 23 Hastings Center Report 32, 36-37 (1995).

Fourth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who are *suffering considerable pain*. No. 95-1858, Pet. App. 5a; No. 96-110, Pet. App. A-9, A-11, A-13, A-48, A-52, A-53. This assumption, however, provides no meaningful standard either. It is also misguided because it ignores the enormous progress in recent years in providing palliative care, which eases pain without curing the patient. See Derek Doyle, *The Physical Control of Pain* in Derek Doyle, ed., *Palliative Care: The Management of Advanced Illness* (1984). Today, in settings where staff has adequate training, it is now routine to control pain fairly easily in 98% of all patients, and to manage pain in those rare cases where pain control is more difficult. *See* Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474 (1996); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 N. Eng. J. Med. 1124 (1996). The very concept of "pain," moreover, is itself a fluid one that does not afford precise guidance for those who would have to administer a newly created regime of physician-assisted suicide. For a graphic example of a physician-assisted suicide involving a person who was probably depressed at the news of her diagnosis, but was not otherwise clinically "suffering pain," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).

Fifth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only in an environment where a physician would prescribe or provide a lethal dose of medication for the patients to take, or where a physician would actually administer the lethal dose to the patients in some circumstances. *See, e.g.*, No. 95-1858, Pet. App. 4a, 12a; No. 96-110, Pet. App., A-9, A-111, A-112. This line, however, is as questionable and untrustworthy as the other four, given the fact that so many in this country have no physician at all to whom they can turn for health care, let alone a physician with whom they have a personal relationship of trust. As we note below, moreover, the state may preserve the integrity of the physician's practice and the traditional role of the doctor in our society, which has been that of a healer, not of a minister of death. In our society doctors are widely recognized as professionals dedicated to delivering, restoring, saving and comforting life. Some doctors are better at this than others, but all doctors – irrespective of their technical skills or particular training – are expected to support life rather than to destroy life. In a regime of physician-assisted suicide, at least some doctors will be recognized as promoters of swift death. The ineluctable result will be that patients will not have the same trust and confidence in the advice their doctors offer. Most troubling, even a suggestion of the possibility that death might be hastened, when made by a doctor to a seriously ill, dependent and suffering patient, will force the patient to justify her remaining existence. We dare not call this "compassion." Indeed, the entire approach of the Ninth Circuit is based on a total misunderstanding of the virtue of compassion, which has to do with bonding with the other and with empathetic caring for the other, not with directly intending to cause the death of the other.

The supposed protections offered by the lower courts turn out to provide an insecure, elusive and deceptive line of defense against abuse. Asserting that only competent, terminally ill patients who voluntarily choose to end their lives because of their intolerable pain will be granted the assistance

of a doctor in ending their lives, is a claim that no legal system can guarantee, a line no court can enforce. If this Court creates a constitutional regime of physician-assisted suicide, even if the patient who is helped to die was not competent to make the decision, or even if the patient's decision was not fully voluntary, or even if the patient was not terminally ill, or even if the patient did not suffer from intolerable and unrelievable pain, or even if the aid in dying was not given by a physician – there will seldom if ever be a successful prosecution. Many will die; few seriously ill persons will be protected.

None of the five elements discussed above is a reliable criterion for a stable constitutional test that would ensure that physician-assisted suicide will be cabined in a manner that would enhance personal liberty. When combined into a five-part test, they do not improve as stable predictors of the future. The line protecting against involuntary euthanasia – even state-encouraged involuntary euthanasia – simply does not hold. The activity allowed by physician-assisted suicide will inevitably fail to satisfy the appetite of those who support it; they will mount unrelenting pressure to expand the limits of the permissible and to go beyond it. The journey down the slippery slope is far too risky to undertake at all, much less on the flimsy assurances against future abuse offered by the lower courts. The line we insist should be maintained between killing a person and allowing a person to die might not always be a perfectly clear line, but over a long period of time it has been vastly more effective at preventing abuse than the untenable line proposed by the lower courts.

F. Legitimate Governmental Interests in Prohibiting Physician-Assisted Suicide

As we have suggested above, to defend a regime of physician-assisted suicide under the rubric of liberty begs a very important question about whose liberty would in fact be promoted by this change. When a state preserves the distinction between killing a person and allowing a person to die, it

promotes the interest in personal liberty; a regime of physician-assisted suicide would not.

Judge Noonan identified five legitimate governmental interests that undergird the prohibition of physician-assisted suicide: (1) the interest in not having physicians in the role of killers of their patients; (2) the interest in preventing abuse similar to what has occurred in the Netherlands where the practice of allowing assisted suicide now includes direct measures taken to end a person's life without a contemporaneous request to do so; (3) the interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths; (4) the interest in protecting the poor and minorities from exploitation; and (5) the interest in protecting persons who are disabled from societal indifference and antipathy. No. 96-110, Pet. App. D-14 to D-17. We discuss the first two interests in this section of the brief because they are directly related to the theme of personal liberty, and the last three interests in Part II below because they are related to the theme of equality. In articulating these governmental interests, Judge Noonan relied on the most comprehensive study of physician-assisted suicide by a governmental body, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994).[7] We now discuss

---

[7] The study was conducted by the New York State Task Force, a commission appointed by Governor Cuomo in 1985, which filed its report in May, 1994. The Task Force was composed of twenty-four members representing a broad spectrum of ethical and religious views and ethical, health, legal, and medical competencies. Its membership disagreed on the morality of suicide. Unanimously the members agreed against recommending a change in New York law to permit assisted suicide. Thus it strikes us as bizarre that a judge in the Second Circuit could have suggested that the issue be remanded to the political process in New York, which had just completed an exhaustive treatment of the issue and had expressly rejected the conclusion urged by the lower court. No. 95-1858, Pet. App. 43a-44a (Calabresi, J., concurring). The en banc opinion in the Ninth Circuit cited this Task Force Report in a footnote, No. 96-110, Pet. App. A-74 note 84, but its opinion does not indicate that the en banc panel actually read the document they asked their readers to "see."

two governmental interests that bear more directly on the theme of personal liberty.

(1) Protecting the role of physicians as healers, not killers.

First, a state has a legitimate interest in not having physicians in the role of killers of their patients. One way of thinking of this interest is that the state may preserve the integrity of the physician's practice, which has for centuries explicitly prohibited doing any harm to patients.[8] More recently and more explicitly, § 2.211 of the American Medical Association's *Code of Medical Ethics* (1994) declares: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."

Another way of thinking of the legitimacy of this governmental interest is that it concerns public health or the well-being of the entire community. Thus, as Judge Noonan suggested, "Not only would the self-understanding of physicians be affected by removal of the state's support for their professional stance; the physician's constant search for ways to combat disease would be affected, if killing were as acceptable an option for the physician as curing. The physician's commitment to curing is the medical profession's commitment to medical progress." No. 96-110, Pet. App. D-15. When the well-being of all persons is diminished by a shift in constitutional standards, that shift cannot be defended as an enhancement of personal liberty.

---

[8] For an extensive treatment of the significance of the Hippocratic Oath, *see* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* (1991); Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (1991); Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (1943); and *see* Brief Amicus Curiae of Christian Medical & Dental Society in No. 95-1858 and No. 96-110.

(2) Preventing the abuse of widespread involuntary euthanasia

Second, a state has a legitimate interest in preventing involuntary active euthanasia. This abuse is not hypothetical. It has occurred in two modern democracies in our own century, the Netherlands and Germany. When these two experiences are explored carefully, several closely related propositions emerge that have a dreadful resemblance to the brave new world we fear will emerge in a regime of physician-assisted suicide. First, high-sounding generalizations about the human good can mask terrible evil. Second, massive self-deception or willful blindness sets in and prevents close empirical inspection of the established program. Third, when the purposes and effects of the norms in society are themselves evil, otherwise good people – including physicians – can become complicit in massive evil simply by taking the easy path of conforming to the "normal." Fourth, the law has an educative function for good or for ill, and a medical program that has the force of law has a powerful ability to shape culture and to confer legitimacy upon atrocity.

Since 1984, legal guidelines in the Netherlands have tacitly allowed assisted suicide or euthanasia in response to a repeated, voluntary request from a suffering, competent, terminally ill patient, the same line drawn by the courts below. In 1991 the government established the Rimmelink Committee to determine the actual number of deaths by euthanasia and to gain insight into this practice. The Rimmelink Committee discovered that by 1990, approximately 2,700 cases of assisted suicide occur annually, amounting to two percent of all deaths.[9] Within less than a decade of this shift in

---

[9] In this country, two percent of deaths would amount to more than 43,000 cases of physician-assisted suicides a year. If this Court intends to set up a regime of physician-assisted suicide confident that abuse can be prevented "while this Court sits," *Panhandle Oil Co. v. Mississippi ex rel. Knox*, 277 U.S. 218, 223 (1928) (Holmes, J., dissenting), its docket will be very full of these cases for years to come.

standards, the Rimmelink Committee concluded that none of the initial lines drawn by Dutch Law had held. In the cases reported to the Committee, Dutch physicians admitted that in 1,000 additional cases they had intentionally taken the patient's life involuntarily, without an explicit request from either patient or family. And there is a large number of unreported cases in this category of "life terminating acts without the explicit request of the patient." *See* New York State Task Force, *When Death Is Sought*, 133-134; Johannes J. M. van Delden, Loes Pijnenborg and Paul J. van der Maas, *The Remmelink Study: Two Years Later*, 23 Hastings Center Report 24 (Nov.-Dec.1993); Subcommittee on the Constitution, House Jud. Comm., *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Cong., 2d Sess. (1996). Whatever else may be said about the sudden and widespread practice of active involuntary euthanasia in the Netherlands, this dramatic shift away from patient involvement in such a momentous decision cannot plausibly be justified as an enhancement of personal liberty.

Recent studies also enable sharp focus on the Nazi program of physician-assisted eugenics and euthanasia that was central to its plan of creating an ethnically pure super-race. *See* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* 68-91 (1991); Ingo Muller, *Hitler's Justice: The Courts of the Third Reich* 120-26 (1991); Robert Proctor, *Racial Hygiene: Medicine under the Nazis* (1988); Benno Muller-Hill, *Murderous Science* (1988); Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* 46-79 (1986). Because of the massive evils perpetrated by the Nazis, *see, e.g.*, Lucy Davidowitz, *The War Against the Jews, 1993-1945* (1975), it is easier to see clearly the evil of the Third Reich than to recognize an analogous situation in the Netherlands or in our own society. As churches with deep historical roots in Germany, we have reflected soberly on the full horror of the Third Reich and on the tragic complacency of the church in the face of that horror. We have searched

fearlessly in this history for sobering lessons that apply to all cultures, including our own.

We acknowledge important differences between Nazi Germany and the current situation of involuntary euthanasia in the Netherlands or the regime we fear would occur in our own country if physician-assisted suicide is imbedded as a constitutional right. And we do not suggest any ideological connection between the Nazis and the respondents or their advocates. Nevertheless, we urge that some lessons might be gleaned from the past as we stand at the precipice of the creation of a new legal order in this country. At least in some respects, the role of some doctors in our future would be distressingly similar to the role some doctors were asked to play in the Third Reich, when large numbers of people in certain groups were judged "unworthy of life." See Lifton, *The Nazi Doctors, supra,* 21-144. That should be enough to give us pause before marching forward in this direction. At the very least, this Court should not lightly toss aside the decision of a state to stand firm by its commitment against physician-assisted suicide in the wake of the experience in the Netherlands.

II. Preserving the distinction between killing a person and allowing a person to die promotes the equal dignity of all persons; a regime of physician-assisted suicide would not.

As we noted above, the Second Circuit repudiated the Ninth Circuit's discovery of a liberty interest in physician-assisted suicide through the methodology of substantive due process. No. 95-1858, Pet. App. 16a-20a. But it held that "[t]he New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." No. 95-1858, Pet. App. 35a. We note again the language relied

upon by the Second Circuit to prevent abuse from physician-assisted suicide, and repeat that – especially in the wake of the recent experience in the Netherlands – these standards afford no protection against sliding down a very slippery slope towards widespread involuntary euthanasia. The narcissistic impulse, moreover, is so deeply entrenched in human life that we have no solid ground for trusting the court's naive faith in the inherent generosity of human compassion.

Although the equal protection methodology employed by the Second Circuit differs at least formally from the substantive due process methodology employed by the Ninth Circuit, the equal protection approach turns out to be just another way of imposing raw judicial power over the political process. Both courts attack the legitimacy of any governmental interest in prohibiting physician-assisted suicide. Since the Second Circuit conceded that there is no fundamental right to suicide, whether assisted or not, it should have deferred to the legislative judgment protecting human life. *See, e.g., Califano v. Aznavorian*, 439 U.S. 170 (1978); *New Orleans v. Dukes*, 427 U.S. 297 (1976); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955). Instead, it nullified the New York statute for essentially the same reasons as those offered by the Ninth Circuit. Only the constitutional shell is different. Hence the reasons we offered in Part I obtain with equal force here.

We comment now on the three other legitimate governmental interests identified by Judge Noonan because they bear directly on the theme of equality.

A. Protecting the elderly infirm from the grave risk of involuntary euthanasia.

A state has a legitimate interest in not subjecting the elderly infirm to psychological pressure to consent to their own deaths. The value of equality in our society may be described as a widening circle of inclusion. For example, at the dawn of the republic, African slaves and women were emphatically not regarded as equal in the eyes of the law. But radical constitutional changes imbedded in the Fifteenth and

Nineteenth Amendments have at least signalled that African-Americans and women are now constitutionally entitled to participate in our democracy by means of the franchise. More recently, momentous legislation has banned invidious discrimination on the basis of race in access to public accommodations, 42 U.S.C. § 2000a (Title II of Civil Rights Act of 1964), on the basis of race and gender in employment, 42 U.S.C. § 2000e (Title VII of Civil Rights Act of 1964), and on the basis of race in housing, 42 U.S.C. §§ 3601 et seq. (Title VIII of Civil Rights Act of 1968). More recently still, older persons have also been protected under the law. *See, e.g.*, 29 U.S.C. §§ 621 et seq. (prohibiting discrimination in employment on the basis of age within specified period of years).

We do not propose that all government policies that would have the effect of placing more significant burdens on older persons must be subject to the most exacting scrutiny previously reserved for racial classifications, or even to the intermediate scrutiny employed in cases involving gender-based classifications. But where, as here, a majority of the states has acted affirmatively to insure that older persons are surrounded with the protection of the laws, we do suggest that it is legitimate for this Court to find that the states have a rational basis for doing so. There is, in short, a plausible connection between a state's prohibition of physician-assisted suicide and its concern for older persons. For one thing, older persons are more vulnerable to the suggestion that, having lived a full life, they have now become a burden to society and even to their family. In these circumstances, it is not unreasonable to maintain that doctors should be the champions and best friends of older persons, not the state-approved harbingers and agents of their death. As Judge Noonan noted, "For all medical treatments, physicians decide which patients are the candidates. If assisted suicide was acceptable professional practice, physicians would make a judgment as to who was a good candidate for it. . . . 'Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation.' "

No. 96-110, Pet. App. D-15, D-16 (citing New York State Task Force, *When Death Is Sought*).

B. Protecting the poor and minorities from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons, especially those without access to health care, from exploitation. In our country over 40 million have no health care insurance at all, and managed health care has increasingly allocated health care services to maximize the economic interests of investors in health care organizations. Under these circumstances, we are deeply troubled that in a regime of physician-assisted suicide health care managers could easily rationalize a decision to induce the death of an unwanted and vulnerable person, whose value in such a system would be measured exclusively in economic terms.

As we noted above, the theme of equality is a widening circle of inclusion. At the beginning of the republic, only property-owners could vote. Again, momentous changes in our century now ensure that the poor may participate in the democracy by means of the franchise. U.S. Const., Amend. XXIV. 42 U.S.C. § 1973 (Voting Rights Act of 1965, as amended); and *Kramer v. Union Free School Dist. No. 15*, 395 U.S. 621 (1969) (eliminating qualification of property ownership for participating in school board elections).

We realize that this Court does not recognize poverty as a suspect classification for purposes of equal protection analysis. *See, e.g., San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1972). These cases are not the vehicle for advocating any change in this approach now. But where, as here, a majority of the states has acted affirmatively to insure that all persons – irrespective of their financial ability to pay for adequate health care[10] – are surrounded with the protection of

---

[10] The burden of inadequate health care continues to fall most heavily on the poor and minorities. *See, e.g.*, Marian Gornich et al., *Effects of Race*

the laws, it is legitimate for this Court to find that the states have a rational basis for doing so. As Judge Noonan noted, "The poor and minorities would be especially open to manipulation in a regime of assisted suicide for two reasons: Pain is a significant factor in creating a desire for assisted suicide, and the poor and minorities are notoriously less provided for in the alleviation of pain. The desire to reduce the cost of public assistance by quickly terminating a prolonged illness cannot be ignored: 'the cost of treatment is viewed as relevant to decisions at the bedside.' Convergently, the reduction of untreated (although treatable) pain and economic logic would make the poorest the primest candidates for physician-assisted and physician-recommended suicide." No. 96-110, Pet. App. D-16 (citing New York State Task Force, *When Death Is Sought*).

C. Protecting older persons from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons who are disabled from societal indifference and antipathy. The widening circle of inclusion has recently expanded to embrace persons with disabilities within its perimeters. Until fairly recently such persons could not participate fully in economic life. The law rendered them invisible as a group. Again, momentous changes in the law now ensure that the disabled may gain access to buildings and thus to education and employment. *See, e.g.*, Vocational Rehabilitation Act of 1973, 29 U.S.C. § 794; Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6001; Americans with Disabilities Act, 42 U.S.C. §§ 12601 et seq.

---

and Income on Mortality and Use of Services Among Medicare Beneficiaries, 335 N. Eng. J. Med. 791 (1996). Thus the state would have an additional reason to ensure that these groups are not singled out for swift elimination because of class or racial prejudices masked under the label of physician-assisted suicide.

We recognize that this Court does not recognize disability as a suspect classification for purposes of equal protection analysis. *See, e.g., City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985). Again, we do not urge a change in this approach now. We merely note that where, as here, a majority of the states has acted affirmatively to insure that persons with disabilities are surrounded with the protection of the laws, it is legitimate for this Court to find that the states have a rational basis for doing so.

As Judge Noonan noted, "The vulnerability of residents of nursing homes and long-term care facilities to physician-assisted suicide is foreshadowed in the discriminatory way that a seriously-disabled person's expression of a desire to die is interpreted. When the nondisabled say they want to die, they are labelled as suicidal; if they are disabled, it is treated as 'natural' or 'reasonable.' *See* Carol J. Gill, *Suicide Intervention for Persons with Disabilities: A Lesson in Inequality*, 8 Issues in Law & Med. 37, 38-39 (1993). In the climate of our achievement-oriented society, 'simply offering the option of 'self-deliverance' shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it.' Richard Doerflinger, *Assisted Suicide: Pro-choice or Anti-Life?*, 19 Hastings Center Report 16, 17 (1989). An insidious bias against the handicapped – again coupled with a cost-saving mentality – makes them especially in need of Washington's statutory protection." No. 96-110, Pet. App. D-16.

Individually and convergently, the five legitimate governmental objectives discussed here outweigh any alleged constitutional liberty of suicide or of assistance in suicide by the medical profession. Both methodologies employed by the lower courts fail on their own terms.

CONCLUSION

Both lower courts have proposed a new constitutional order that would in a single stroke undermine the healing function of doctors by allowing them to become ministers of

death. Yet each court has cast doubt on the rationale of the other. The Second Circuit expressly rejected the substantive due process claim to assisted suicide adopted by the Ninth Circuit. The original panel in the Ninth Circuit rejected the equal protection claim that formed the basis for the analysis espoused by the Second Circuit; the en banc panel did not reach this claim. Thus the judges who would impose this result on our nation have not produced a coherent rationale for the startling departure in criminal law and constitutional interpretation that they propose. Uncertainty abounds on both predicates for the decisions advanced below. This court should not create a new constitutional regime of physician-assisted suicide, which would neither advance human freedom nor promote the equal dignity of all persons. The wiser course of action for this Court to pursue would be to reaffirm the role of the several states in surrounding human life with protection. The lower courts should be reversed.

Respectfully submitted,

EDWARD MCGLYNN GAFFNEY
Valparaiso University
School of Law
Wesemann Hall
Valparaiso, IN 46383
219-465-7834
FAX: 219-465-7872
* *Counsel of Record*

PHILLIP H. HARRIS
General Counsel
Evangelical Lutheran
Church in America
8765 West Higgins Road
Chicago, IL 60631
773-380-2604

SUSAN D. REECE MARTYN
HENRY J. BOURGUIGNON
University of Toledo
College of Law
Toledo, OH 43606
419-530-4212
FAX: 419-530-2821

Attorneys for Amicus Curiae

APPENDIX A

The Evangelical Lutheran Church in America, 1992 Message on End-of-Life Decisions

With this message, the Church Council of the Evangelical Lutheran Church in America, upon the recommendation of the Division for Church in Society, addresses some timely aspects of end-of-life situations and encourages further deliberation on the topic throughout this church. This message does not deal with the full scope of these complex matters. It draws upon a relevant social statement, "Death and Dying," of a predecessor church body as basis for the guidance it offers.[1]

The Occasion

An elderly woman contemplates in terror the possibility that she might be kept alive for months by means of life-support systems. A son visits a nursing home weekly to see his 95 year-old mother, who is stricken with Parkinson's disease and who wants to die. Family and friends share the slow, anguishing death of a young man with AIDS. Parents agonize with their pastor over what to do about their daughter who survives in a persistent vegetative state after a car accident.

Increasingly, people know from their own experience similar painful dilemmas. While the achievements of modern medicine have been used to prolong and enhance life for many, they have also helped create an often dreaded context for dying. Costly technology may keep persons alive, but frequently these persons are cut off from meaningful relationships with others and exist with little or no hope for recovery. Many fearfully imagine a situation at the end of their lives where they or their trusted ones will have no say in decisions about their treatment.

In this context, new emphasis is being placed on the rights of patients. Recent federal legislation, for example, requires all health care facilities receiving Medicare or Medicaid monies

to inform patients of their right to make medical treatment decisions. This includes the right to specify "advance directives,"[2] which state what patients wish to be done in case they are no longer able to communicate adequately.

We consider the legislation consistent with the principle that "respect for that person [who is capable of participating] mandates that he or she be recognized as the prime decision-maker" in treatment.[3] The patient is a person in relationship, not an isolated individual. Her or his decisions should take others into account and be made in supportive consultation with family members, close friends, pastor, and health care professionals. Christians face end-of-life decisions in all their ambiguity, knowing we are responsible ultimately to God, whose grace comforts, forgives, and frees us in our dilemmas.

Which decisions about dying are morally acceptable to concerned Christians, and which ones go beyond morally acceptable limits? Which medical practices and public policies allow for more humane treatment for those who are dying, and which ones open the door to abuse and the violation of human dignity? Proposals in various states to legalize physician-assisted death[4] point to renewed interest in these old questions. ELCA members, congregations, and institutions need to address these questions through prayer and careful reflection.

A Christian Perspective

Our faith as Christians informs and guides us in approaching personal and public decisions about death and dying today. Among the convictions that orient us are:

- life is a gift from God, to be received with thanksgiving;
- the integrity of the life processes which God has created should be respected; both birth and death are part of these life processes;

- both living and dying should occur within a caring community;
- a Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions;
- truthfulness and faithfulness in our relations with others are essential to the texture of human life; and,
- hope and meaning in life are possible even in times of suffering and adversity a truth powerfully proclaimed in the resurrection faith of the church.[5]

"Whether we live or whether we die, we are the Lord's" (Romans 14:8). For those who live with this confidence, neither life nor death are absolute. We treasure God's gift of life; we also prepare ourselves for a time when we may let go of our lives, entrusting our future to the crucified and risen Christ who is "Lord of both the dead and the living" (Romans 14:9).

While these convictions do not give clear-cut answers to all end-of-life decisions, they do offer a basic approach to them.

Allowing Death and Taking Life

Withholding or Withdrawing Artificially-administered Nutrition and Hydration

Patients who once would have died because of their inability to take food and water by mouth can today be kept alive through artificially-administered nutrition and hydration. These measures are often temporary and allow many to recover health. At other times, however, they alone maintain life, and they may do so indefinitely. In those cases, is it ever morally permissible to withhold or withdraw such measures?

Food and water are part of basic human care. Artificially-administered nutrition and hydration move beyond basic care to become medical treatment. Health care professionals are not required to use all available medical treatment in all circumstances. Medical treatment may be limited in some instances, and death allowed to occur. Patients have a right to refuse unduly burdensome treatments which are disproportionate to the expected benefits.

When medical judgment determines that artificially-administered nutrition and hydration will not contribute to an improvement in the patient's underlying condition or prevent death from that condition, patients or their legal spokespersons may consider them unduly burdensome treatment. In these circumstances it may be morally responsible to withhold or withdraw them and allow death to occur. This decision does not mean that family and friends are abandoning their loved one.

When artificially-administered nutrition and hydration are withheld or withdrawn, family, friends, health care professionals, and pastor should continue to care for the person. They are to provide relief from suffering, physical comfort, and assurance of God's enduring love.

Refusal of Beneficial Treatment

Patients and health care professionals share a common concern that medical treatment be beneficial. In most situations, they have a common understanding of that benefit. When agreement exists, patients generally are willing to receive treatment. There are situations, however, when patients and health care professionals disagree on what will benefit the patient, or on whether the expected benefit is worth the risks and burdens involved. What is morally responsible in these situations?

Because competent patients are the prime decision-makers, they may refuse treatment recommended by health care professionals when they do not believe the benefits outweigh the risks and burdens. This is also the case for patients who are incompetent, but who have identified their wishes through advance directives, living wills, and/or conversation with family or designated surrogates.

Health care professionals are obligated to inform patients of medical treatment options and what in their best judgment are the potential benefits and burdens of such options. They are also obligated to obtain the consent of patients to provide treatment. Where this consent is not given, they should accept the desired limits of treatment, even when they do not agree with the decision.

A patient's refusal of beneficial treatment does not free health care professionals from the obligation to give basic human care and comfort throughout the dying process which may follow. Family, friends, and pastor need to accompany the person and share the promise of God's faithfulness in life and death.

Physician-Assisted Death

An emphasis on patients' rights, a health care system often unable to respond adequately to catastrophic illness, and the emergence of disease processes (such as AIDS and Alzheimer's disease) that threaten dramatic loss of human capacities are a few of the realities that have converged to create an environment where some patients ask that their life be ended. Is it ever morally permissible for a physician deliberately to act or authorize an action to terminate the life of a patient?

The integrity of the physician-patient relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals

also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death.

However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. As a church we affirm that deliberately destroying life created in the image of God is contrary to our Christian conscience.[6] While this affirmation is clear, we also recognize that responsible health care professionals struggle to choose the lesser evil in ambiguous borderline situations – for example, when pain becomes so unmanageable that life is indistinguishable from torture.

We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased.

Caring treatment that allows death to occur within the bounds of what is morally acceptable may help reduce the appeal of physician-assisted death. Hospice care offers promise of more humane treatment at the end of life. A more equitable health care system that more effectively responds to catastrophic illness and provides the needed follow-up care should also be a priority for those concerned about end-of-life decisions.

Ministry in Preparation for the End of Life

Advance directives are welcome means to foster responsible decisions at the end of life. Yet people are often overwhelmed and frightened when thinking about medical treatment and legal possibilities, and therefore do not take steps to prepare for the end of their lives. People recognize their rights as patients but at the same time feel unprepared to take on the responsibility.

Communities of faith should, can, and often do provide holistic ministry to prepare people for end-of-life decisions. Pastors can help people to deal with their fears and hopes. Congregations can offer opportunities for conversation and deliberation about the end of life. They can invite hospital chaplains, hospice care-givers, social workers, attorneys, or others knowledgeable about advance directives to help them consider the topic's many dimensions.

Church related hospitals, nursing homes, and other social ministry organizations are also encouraged to provide for continuing conversation and deliberation about their ministry at the end of life. The staff of these organizations need to understand the ethical principles that are to guide the care they provide. Ethics committees can play an important role in dealing with unresolved conflicts about treatment decisions.

We rejoice in the faithful and compassionate congregations, pastors, health care professionals, and church institutions who minister with persons who are dying and their families and friends. We give thanks for family and friends who minister to their loved ones. In the midst of often agonizing end-of-life decisions, we are reminded of the God-given mystery of both life and death. May the Holy Spirit grant to us all loving wisdom and confident hope in the Gospel's promise of eternal life.

Endnotes

[1] The social statement, "Death and Dying," was adopted in 1982 by the Lutheran Church in America. In 1977 The American Lutheran Church developed an analysis paper, "Death and Dying," which was not an actual social statement, but also provides background for this message. Both are available from the ELCA Distribution Service.

[2] "Advance directives" commonly include designation of a durable power of attorney, living wills, and an advance directive form. The exact meaning, however, may vary from state to state.

[3] LCA, "Death and Dying," p. 3.

[4] Physician-assisted death or "aid in dying" refers to situations in which a physician (or other health professional at the physician's request), in response to a patient's request, either administers a medication or performs a treatment, or enables the patient to do so, with the intent of bringing about that patient's death.

[5] The above convictions are quoted from LCA, "Death and Dying," pp. 2-3.

[6] LCA, "Death and Dying," p. 6.